TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR MEDICAL CENTER AT TROPHY CLUB

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-1127-01

MFDR Date Received
December 27, 2016

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original billing was submitted and denied and the subsequent reconsideration denied as well due to lack of approval. Services were approved prior to being performed."

Amount in Dispute: $2,881.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim number] is in the Texas Star Network... Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's name and for its tax identification number, and found no evidence TROPHY CLUB MEDICAL CENTER LP is a participant in that Network... Because this fee reimbursement dispute involves a Network requirement under the Insurance Code and not the Labor Code, Texas Mutual argues DWC MDR has no jurisdiction in this matter. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY DISPUTED SERVICES

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Ordered
March 24, 2016	Outpatient Facility Charges	$2,881.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

Issue

1. Did the requestor render services to an injured employee enrolled in a certified network?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed this medical fee dispute with the Division requesting resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply the Texas Labor Code (TLC) statutes and rules, including 28 TAC §133.307 and is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that

"Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." The requestor therefore has the burden to prove that the condition(s) outlined in Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution. The following are the Division's findings.

The services in dispute were denied with reduction code(s) "CAC-243 – Services not authorized by network/primary care providers" and "727 – Provider not approved to treat Texas Star Network claimant." Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103." The requestor, therefore has the burden to prove that it obtained the appropriate approval from the certified healthcare network for the out-of-network care it provided. The requestor, in its position summary states, "Attached you will find...a copy of the authorization reference number [preauthorization number] with a start date of 3-22-16 and an end date of 04-22-2016 authorizing CPT code 26608." Although a letter dated March 23, 2016 and March 22, 2016 supports that the physician Scott Gibson, D.O., received an out of network referral and preauthorization for the procedure from the Certified Network, no documentation was found to support that the requestor received its own, separate approval from the Certified Network to treat the injured employee at its location. The Division concludes that the requestor did not receive approval from the Certified Network to treat the injured employee; thereby failing to meet the requirements of Texas Insurance Code Section 1305.006(3).

The requestor failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

2. The Division finds that the disputed services were rendered to an in-network injured employee. The TDI rules at 28 Texas Administrative Code §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The Division finds that the disputed services may be filed to the TDI Complaint Resolution Process, if the facility is dissatisfied with the outcome of the network complaint process. The complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 and may be the appropriate administrative remedy to address matters related to health care certified networks.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered. The Division finds that this dispute is not under the jurisdiction of the Division of Workers' Compensation and is therefore, not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 13, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division, within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form, or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).